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"While they were saying among themselves 'It can not be done' it was done."

—Helen Keller

Mobility and Orientation—A Symposium

Last June, a national conference on mobility and orientation, sponsored by the U. S. Office of Vocational Rehabilitation, was held at the American Foundation for the Blind. It was attended by more than a dozen people from across the country representing various competencies, particularly orientation and mobility instruction and program planning of services for blind people.

At a meeting of the National Council of State Agencies for the Blind at the time of the 1959 National Rehabilitation Association conference in Boston, the June conference on mobility instruction was reported on and its conclusions were favorably viewed. On the basis of this fact, Louis H. Rives, Jr., chief of the Division of Services to the Blind of the Office of Vocational Rehabilitation, has announced, it is the intention of the OVR to implement the plan as enunciated, as rapidly as the standards can be met with regard to agency sponsorship, faculty, and academic habitation.

In order to encourage as widespread discussion as possible, we are glad to publish in this issue a modified and shortened version of the formal report of the conference, followed by three individually authored articles on various facets of mobility and orientation. In the first of these three, the author is concerned with the problems of formulating training programs for mobility instructors. The author of the second paper discusses values of orientation and mobility that serve the blind person in his vocational pursuits. The last paper considers factors in orientation and mobility for blind children, with emphasis on mobility aids.

Further contributions on the general subject or on specific phases will be welcomed by the New Outlook.—Ed.

I. National Conference on Mobility and Orientation

THE PURPOSE OF THE CONFERENCE was to establish criteria for the basic selection of mobility and orientation personnel; to develop a well-balanced curriculum; and to recommend length of training and appropriate sponsorship.

The following subjects were discussed: Goals of the Conference; Conference Focus; Development of a Curriculum for Mobility Instructors; The Importance of Mobility and Orientation Training to The Newly Blinded Individual; Criteria for the Selection of Mobility Instructors; and Criteria for the Location and Affiliation of Training Courses for Mobility Instructors.

To establish an understanding of the juncture in work with the blind at which the conference was held, three resource persons prepared background material in terms of which the purpose of the conference was understood. Papers were prepared by Richard E. Hoover, M.D., and Father Thomas J. Carroll, director of the Catholic Guild for the Blind, Boston, Mas-

sachusetts, and seminar material by Dr. Frederick M. Jervis, director of counseling, University of New Hampshire, in Durham.

Rationale

It was the consensus of the conference that it would be a very great error for any established and recognized authority to support training of mobility instructors within a special learning period of less than a year of graduate study. Hazard to life and limb of blind trainees later to be under tutelage was a consideration in this time element which carried equal weight with the subtle influence of the trainer in so trusted a teaching relationship, involving, in the words of one blind participant at the conference, the blind trainee's wish "to live or die."

The gravest warnings were issued by the orientation and mobility instructors at the conference, especially one with thirty years' experience and another with fourteen years of experience. These members of the group without animus declared they were unwilling to be a part of the training of mobility instructors on a short-term basis, however concentrated, inasmuch as all they knew from their teaching belied the effectiveness of brief training periods of instruction. Necessary emotional conditioning was so intricate a process, the engraining of principles through time-consuming laboratory experience so necessary, that the needs of the situation could not be met in a compressed teaching program of two weeks, two months, or even four months.

This stand gained something from its relation to a second point which was firmly made by the majority of the group. This was that the teaching of mobility was a task of a sighted, rather than a blind, individual. Aware of the fact that this was opposed to classic theory of pioneers in the field, the great majority of the conference maintained that all experience indicated a revision of the theory.

When discussion had established this principle, the need for a year's training gained substance, as the necessity for practical laboratory experience was taken into account. Obviously, the demands of the situation would be a deep identification with blindness and something of what it entailed on a basis so intimate and particular that the instructor would gain the habit of thinking all the time about how to manage problems of living without sight. This would entail living through a number of stages of identification while acquiring techniques.

Standards for Selection of Personnel

It was concluded that the following standards should govern the selection of personnel:

1. Academic. Bachelor's degree with academic studies preferably in education, biological sciences, psychology and sociology.

2. Physical. (a) Vision: No visual impairment not correctible to 20/20. No errors in visual field under all common circumstances, and no evidence of pathology contributing to progressive deterioration; (b) Hearing: Normal; (c) Physical condition: Good.

3. Personal Characteristics. It was the consensus that a paragon of all virtues was not required. The basic essential as laid down by an experienced trainer is that the orientor "be an honest kind of fellow." The consulting psychologist stressed "the ability to get on with people. . ." (not mentioning "liking people" but giving stress to effective relationships which might well be courteously professional rather than warm). Keen observation and the ability to interpret observation were also cited in many synonyms. A major factor mentioned again and again was "common sense," by which the group appeared to mean a combination of mother wit leading to the classic ability to distinguish between right and wrong, and the fatherly knowledge of human error which could estimate delicately the occasion to admonish the client in the words of one master orientor, "Listen, brother, you are not doing what is expected." A charac-

ter capable of meeting the demands of emotional stresses in a creative, realistic, optimistic way stood at the center of all the words the group addressed to the concept of the orientation or mobility instructor. Special stress was laid on the work habits of an experienced instructor summed up by "a controlled desire to get things done." This was to be predominant and to weigh more than "fighting spirit," which, however appropriate in soldier, sailor, and other roles, must be "very well in hand" in the mobility instructor. The compulsion to utter, however desirable on the platform or in the press, was censored out of the make-up of the orientor type, whose communication tendencies were brought to the fore by the phrase "large ears, small mouth."

Words amounting to deeds were suggested in the need for clarity and usefulness in all utterance in the teaching situation. Specifically, it was decided that it was easier to determine what an orientor should not be rather than what he should be. The following traits were listed as especially undesirable: (a) impatience; (b) possessiveness; (c) impulsiveness; (d) intolerance; (e) embarrassment over the job; (f) dishonesty; and (h) morbidity. Desirable traits stressed were flexibility and ability to compromise.

Curriculum

It was recommended that five broad areas of study be included in the curriculum. These areas should be explored and mastered through seminars, personal tutoring of the student by a "master orientor" on a one-to-one basis, reading, and lectures. This entire learning process should be geared to real life situations through concurrent laboratory experiences and clinical practice. (The term "laboratory" as used in this context should be taken broadly to mean all the resources available for directed observation. The term "clinical practice" should be taken to mean supervised teaching.) The five areas of study are: 1) Physical orientation and mobility; 2) Dynamics of human behavior related to blindness; 3) Functions of human body in relation to blindness; 4) The sensorium and its relation to blindness; and 5) Cultural and psychological implications of blindness.

1. Physical Orientation and Mobility

It was recommended that physical orientation and mobility be taught through the means of practice-teaching, clinical training or internship. The procedures for conducting this practice-teaching would be: 1) learning the essential skills and techniques of orientation and mobility under a blindfold; 2) observation in a setting of skilled personnel working with blinded individuals; and 3) supervised teaching of blind persons.

It was foreseen that observation and supervised teaching would take place: 1) in in a school setting; 2) in the center setting; 3) in the agency setting; and 4) in the hospital setting. It was understood that in all settings mobility instructors would of necessity work beyond the confines of the school, agency, or hospital. It was also foreseen that management of such a teaching program would necessitate special handling according to the needs of clients categorized in several different ways, such as 1) totally blind compared with partially seeing, and 2) the complete novice as compared with the awkwardly experienced, one of whom would require basic or primary teaching, the other remedial work. The further necessary division was foreseen in working with young children where the parental factor enters the teaching relationship. Other special groups requiring different types of handling were individuals with multiple handicaps and the aging, both inexperienced with blindness, and those encountering new problems in the management of themselves because of geriatric problems recently acquired.

The conference discussed mobility in terms of the classic guide-dog training and the so-called Hoover or Hines method of

orientation,* since both represent a body of knowledge backed up by documentation and personal testimony regarding a large number of trainees, approximately forty-five hundred in the first instance and one thousand in the second. However, the spirit of discussion tended constantly toward research and exploration of new methods, and leaving an open door toward any new creative approaches other than by guide-dog or cane, should such developments be offered. Nevertheless, discussion arrived at a consensus which drew a distinction between mobility instruction leading to an individual's "getting about on his own" and the teaching of use of guides, procurement of guides, adjustment to guides, poise, self-command, and independence while using a guide. All these could be adjunctive to mobility, but it was the consensus that they were *not* mobility itself in the sense used in the formulation of the above learning experience. A special hazard to standards was seen in this area. It was especially recommended that physical orientation and mobility should include toward the end of the learning experience a very careful study of accidents occurring to blind persons going about on their own.

2. Dynamics of Human Behavior Related to Blindness

It was recommended that formal attention be given to special human problems resulting in necessary modification or extension of action in the presence of blind people. Specifically, it was shown that there was a necessity for adroit and careful scrutiny of the instructor's own emotional reactions and personal habits in relating to blind people. It was suggested that a wide range of considerations lay in this area which would require diversified teaching skills, since at one end lay mere courtesy modified to take blindness into account, and at the other what amounted to psychotherapy of students. It was brought out that in the area of communication alone, the development of descriptive powers would require extensive practice in awareness and useful techniques. This whole subject borders on cultural and psychological implications as described hereafter.

3. Functions of the Human Body as Related to Blindness

It was recommended that the human body *as related to blindness* should be studied in the following areas: 1) anatomy and physiology; 2) hygiene; 3) kinesiology; 4) orthopedics; and 5) remedial exercises. It was thought that special understanding of the bone system, the muscle system, and the nervous system should be acquired.

4. Sensorium

Akin to the above considerations but requiring special attention is the sensorium. It was noted that this area was at the moment in a state of flux due to burgeoning theories, but might become the most promising area by which a better program of mobility could be related to research. Traditional learning on the subject should be conveyed to trainees, especially bringing to the fore the importance of the olfactory, aural and other well-recognized senses and the necessity for their interpretation and coordination of their use.

5. Cultural and Psychological Implications of Blindness

It was recommended that cultural and psychological implications of blindness be a special area of study by which broad views of attitudes concerning blindness might be brought into the picture, and the entire teaching program related to other

---

** The methods here mentioned are designed to accomplish the same end result. The guide-dog training has been in existence for a somewhat longer period. The Hoover or Hines regime of therapy is based on a use of the cane not practical before the development of techniques for producing and bending extremely light metal. Canes long enough to precede the user by one step, but weighing no more than six ounces, when manipulated in an arc serve as both bumpers and probes. The psychological as well as the physical intricacies of this system require extensive training.*

disciplines. Some flexibility was considered advisable in assigning content to this area with leeway for passages of responsibilities to and fro between this area and the area designated "Dynamics of Human Behavior." This would be according to the inclination and talents of faculty assigned to organizing the learning process.

In any case, cultural implications would include attitudes concerning blindness and changing patterns in these attitudes, ideals set forth for dealing with problems of blindness, and, finally, some knowledge of success and failures in the implementation of these ideals.

Type of Training Facility

It was recommended that the training facility be in a university setting where there is a medical school and available laboratory facilities of excellent quality. These latter should be agencies serving the blind, affording a wide range of laboratory experience to include, if possible, work with blind persons not previously trained, and with those who present a variety of special problems. An opportunity should also be provided for work in hospital settings with newly blind persons or those who have never had training as blind persons.

It was suggested that the setting be in a metropolitan area, in a department of a university which had freedom on the campus to draw instructional staff from various departments or schools of the university, and with access to facilities for the laboratory practice. It seemed essential that the university be especially strong in research, particularly research in neurology and electronics. Finally, it seemed desirable that the university have an on-going program of rehabilitation counseling under the sponsorship of the Office of Vocational Rehabilitation.

Participants

Conference coordinator was Arthur L. Voorhees, program specialist in vocational and rehabilitation services, American Foundation for the Blind. Conference recorder was C. Warren Bledsoe, assistant chief of the Division of Services to the Blind, Office of Vocational Rehabilitation. Helen Isaac served as conference secretary.

Participating in the conference were: Georgie Lee Abel, program specialist in education, American Foundation for the Blind; Oliver Burke, chief of mobility and orientation, Arkansas Enterprises for the Blind, Little Rock; William Debetaz, vice president, The Seeing Eye, Inc., Morristown, New Jersey; Irving J. Kruger, rehabilitation instructor, New Jersey State Commission for the Blind; Harold Richterman, director of rehabilitation services, Industrial Home for the Blind, Brooklyn, New York; Ed Ronayne, resource teacher, Evans School, Denver, Colorado; Keane Shortell, mobility instructor, Industrial Home for the Blind, Brooklyn, New York; Frederick A. Silver, mobility therapist, St. Paul's Rehabilitation Center for the Blind, Newton, Massachusetts; Stanley Suterko, supervisor of orientation therapy, Blind Rehabilitation Section, Veterans Administration Hospital, Hines, Illinois; Russell Williams, chief, Physcial Medicine and Rehabilitation Division, Veterans Administration, Washington, D. C.; and Charles C. Woodcock, principal, Oregon State School for the Blind, Salem.

Speakers

The following speakers addressed the conference: M. Robert Barnett, executive director, American Foundation for the Blind; Father Thomas J. Carroll, director, Catholic Guild for the Blind, Boston, Massachusetts; Kathern F. Gruber, director, Division of Research and Specialist Services, American Foundation for the Blind; Dr. Richard Hoover, ophthalmologist, Baltimore, Maryland; and Dr. Frederick M. Jervis, director of counseling, University of New Hampshire, Durham.

The conference, sponsored by the U. S. office of Vocational Rehabilitation, was held June 8-12, 1959, at the American Foundation for the Blind, in New York.

II. The Dilemma in Training Mobility Instructors

HERBERT RUSALEM, Ed.D.

This article was written prior to the publication of the report of the mobility conference, which appears in condensed form in the preceding pages. The author wishes it understood that this paper was written without reference to the conference and without knowledge of its deliberations; and that it should not be seen as a critique of the conference nor as a challenge to its findings. It is merely an expression of a point of view arrived at independently by a single individual.—Ed.

PSYCHOPHYSICALLY, the loss of freedom of movement among blind persons is a major limitation. With few exceptions, normal human movement is guided by vision. With the loss of sight, mobility becomes a monumental challenge. Even among the best-equipped and most highly trained blind persons, getting from one place to the next requires the utmost of attention, skill, and courage. In the early stages of blindness, psychological problems combine with limited community training resources to accentuate the difficulty. In persons less recently blinded, cumulative fear, impaired motivation, and poor walking habits may add to the dimensions of the problem.

One of the major techniques used to reduce the barriers to successful mobility and to inculcate positive new mobility habits among blind persons is cane travel. Although other means of mobility have received considerable attention, the majority of blind individuals travel with the cane. Since World War II, when the Hoover technique was formalized, mobility training in the use of the cane has been available to blind persons in some centers. The evidence, however, is that a large proportion of blind persons in this country have not yet had the benefits of such training. The reason most often is that the training is simply not available in the blind person's community. In some cases this deficiency may be due to the failure of administrators to recognize the value of and need for mobility instruction. In others, funds may be lacking to initiate and support a program. Finally, even where administrative insight and sufficient funds are present, programs may be deterred by the lack of mobility instructors. It is with this latter problem that this paper is concerned.

It is a fact that the number of foot-travel instructors is sharply limited. This scarcity constitutes one of the major problems in making mobility instruction available to all blind persons who can benefit from it. As a result, there is a mounting interest in evolving techniques of recruiting and preparing such specialists for service to blind persons. Up to the present, efforts have been spasmodic and unorganized. Mobility instructors have been recruited from many walks of life, have been prepared for their functions through many avenues of preparation, and have functioned in their jobs

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under numerous administrative arrangements. Sometimes, agencies have recruited almost any individual who seemed able to learn the technique and communicate it to a blind person. Obviously, this procedure has been unsatisfactory.

The current status of mobility instruction reveals symptoms that suggest the need for a reappraisal. Among these symptoms are:

1. Essential minimum foot-travel instruction is still unavailable to many blind individuals in the United States.

2. The personal and professional characteristics of mobility instructors have not been identified.

3. There is no center at which mobility instructors may be prepared.

4. The elements of mobility have not been sufficiently studied, organized, and codified to justify curriculum building and the development of a body of knowledge.

5. Relatively few of the present heterogeneous group of mobility instructors perceive mobility instruction as a career. Many are looking toward entrance into other fields which promise greater status and income.

6. Relatively few individuals voluntarily select mobility instruction as a career.

Proposals Analyzed

Many of the perceptive leaders in service to blind persons have been sensitive to these symptoms and the concurrent weakness in mobility instruction in many parts of the country. The problem has been aired at informal discussions as well as in rehabilitation group meetings. It may be helpful to examine some of the proposals which have been made and to suggest some constructive courses of action.

PROPOSAL I: *A curriculum in mobility instruction can be constructed at a round-table meeting attended by experts in mobility.*

The development of a professional curriculum is a complex process which cannot take place within the framework of group meetings of technical experts. Such experts are thoroughly familiar with the principles and techniques of their craft, but have little or no training in the skills of establishing curriculum.

The basic steps in curriculum development are:

1. A "job analysis" of the area in which curriculum is to be developed.

2. Research into the current status and needs of the field.

3. "Teasing out" the aspects of the field, if any, which differentiate it from other fields.

4. The establishment of relationships between the field of study and other fields.

5. A survey of literature bearing on the field.

6. A study of persons currently functioning in the field.

7. The organization of all research materials into a full description of the field, and studies of these materials by curriculum experts to ascertain major outlines of a curriculum, if indeed, a curriculum is indicated.

8. The presentation of the major curriculum outline to technical experts and curriculum specialists for discussion and evaluation.

9. On the basis of recommendations made in step 8, setting up the general curriculum structure and assigning specialists to fill in the details.

Current efforts at solving the mobility instruction problem have not taken this road. Any other path represents a pooling of individual and limited experiences, unassisted by research data and professional curriculum consultation. The establishment of a curriculum is sometimes seen by untrained persons as a process of suggesting a few pertinent courses and selecting an institution which will offer them. Nothing could be further from the truth. Curriculum builders study a field of knowledge intensively, identify content and methods which seem appropriate to it, experiment with various approaches, and evolve a plan of study, of which the discrete

courses are only considered important late in the curriculum construction process.

Since mobility instruction is so universally seen as a vital area of service to blind persons and since it constitutes such a crucial problem, there seems little justification for the use of armchair conference methods exclusively to develop curricula. Some of the difficulties which we have experienced in our field have come about through lack of contact with the activities of professional persons in other fields of service. Neither psychology nor social work would conceive of developing curriculum through a short-term workshop. In fact, in both professions, long-term study and research have formed the substructure of an exceedingly detailed and lengthy consideration of curriculum problems. Mobility instruction, as a field of service, warrants no less.

PROPOSAL II. *Training in mobility instruction should be carried forward on a graduate level in order to "raise standards."*

The present era in service to the blind will probably be recognized as one in which great progress was made in elevating professional standards in the field. The current climate of opinion is warmed by a leadership which sagaciously feels that adequate professional training will enhance service to blind persons. As a result, training programs have been established, hiring standards have been raised, and new entrants into service to the blind more than ever before are professionally prepared to give skillful help in a professional manner.

The elevation of standards, however, is not exclusively a process of demanding ever higher university degrees. It is primarily a process of identifying the skills and knowledge as well as the personal and professional characteristics required to perform certain professional functions. Once these have been identified, realistic hiring and training standards can be established in terms of the specific occupation. For example, it would be easy to quarrel with a recommendation that supervisors of vending stands should have a doctorate in social work or psychology, or that workshop foremen should have a master's degree in vocational counseling. Obviously, the elevation of standards in these areas is more a matter of appropriate training than of university degrees.

Conceivably, an arbitrary decision to demand the master's degree and a graduate curriculum for mobility instructors may be consistent with reality. However, this will not be known until a complete and detailed research study of the field has been made by individuals who are skilled in job analysis, curriculum construction, and professional training, and who are free of bias and special interests. Among the factors which will have to be considered are those which differentiate successful from unsuccessful mobility instructors who are in current service; the undergraduate background, if any, which is most related to success in mobility instruction; and the desirability and need for graduate instruction.

At present, a search of the literature and discussions with mobility instructors and those who use their services fails to signify the need for graduate training. Admittedly, however, this sample of experience is limited. Evidence may later be developed which suggests another conclusion. Such evidence does not now exist. In fact, it may even be hypothesized that graduate training may affect mobility instruction as it does placement counseling, where personnel difficulties abound. It has been exceedingly difficult to retain good placement counselors. One of the dynamics here is that these counselors have been recruited from a variety of fields. In an effort to raise standards, many of them have entered graduate curriculum in rehabilitation and vocational counseling. Soon they begin to perceive themselves as vocational counselors or rehabilitation counselors, capable of engaging in a profession which, for them, has greater interest, breadth, and status. Without knowing precisely what we

are doing, is it possible that we will be training mobility instructors right out of the field?

PROPOSAL III. *Mobility instruction is a profession for which professional training may be established.*

At this point, mobility instruction is more of a function than a field of work. It lacks the body of subject matter, the professional sense of organized unity, the professional ethics and direction, and the defined area of functioning which characterize the professions. Whatever is currently done in relation to the field of mobility instruction will not be based upon its current status as a profession. It will be based upon wishful thinking that it may one day become a profession. However, even this is unlikely. There is a narrowness of delimitation in the function which suggests that, rather than being a profession itself, it is an aspect of another and larger profession.

Any attempt to create professional curricula for mobility instructors should recognize the current feeling that there should be no professions indigenous to service for the blind. This feeling has its roots in many sound ideas. Among others:

1. Blind persons are not so different that their needs require special professions.

2. Training limited exclusively to work with a specific disability group imposes a marked limitation on the occupational mobility of those entering the field. One of the earlier problems in service to the blind was that this practice produced many stagnant pools of workers who were prevented, by limited qualifications or exclusive training, from moving readily from one agency or area of service to another.

3. It is recognized that there is no such profession as work for the blind. Special knowledge and skills are required for service to the blind only insofar as they are adapted from the recognized professions.

For these reasons, the current tendency, enunciated by national agencies and leaders in the field, is to broaden professional education within the recognized fields, introducing specialization subsequently through in-service or other training, and to avoid training curricula which delimit the function of the worker to specific disability groups.

With respect to mobility instruction, the basic question is: Is there a body of knowledge so well organized and discrete as to constitute the core of a professional training curriculum in mobility instruction? Subsequent study may establish this to be so. At present, however, the evidence does not support this hypothesis. In fact, the most comprehensive manual on mobility instruction for blind persons contains fewer than a hundred pages. The specific subject matter in this field is modest. The related subject matters are broad, but such broad training in physical education, anatomy and physiology, vocational counseling, social work, etc., would not produce a unique profession but an amalgam of many disciplines which, as of now, is formless and without a discipline.

PROPOSAL IV. *It will be possible to attract and retain competent persons on a master's degree level in mobility instruction.*

Even in the present status of mobility instruction, in which degrees are not required and selection procedures are not formalized, it has been exceedingly difficult to retain well-qualified mobility instructors. Among the seeing persons who have held these jobs, the turnover is rapid. At the Industrial Home for the Blind, the four most recent instructors have moved on to executive positions, rehabilitation counseling jobs, and related fields. This pattern is repeated all over the country. Some may point to a large group of mobility instructors who are partially seeing and who have had considerable tenure on the job. Does this fact represent job satisfaction and adjustment or does it represent the captive nature of such limited and limiting positions? An impression which should be confirmed by research is that

alert, creative, well-trained mobility instructors soon begin to develop other vocational aspirations.

Admittedly, current salaries and social status play an important role in this situation. The job seems too narrow to maintain the continued creative interest of a superior individual with a master's degree. Even in physical therapy, which is infinitely broader than mobility instruction, this writer has observed in the course of research that there is a restiveness which seems to spring from the technique of orientation and the limited sphere of interpersonal relations. In creating a new profession with new professional training are we also creating a new focus of job dissatisfaction? Is another realistic approach one which identifies the personal characteristics which lead to stable career patterns in mobility instruction and which bases entrance qualifications and training requirements on what is actually demanded on the job?

Summary

It has been suggested in this paper that the current problems in mobility instruction in service to the blind will not be solved by: (a) Armchair curriculum-building methods; (b) The creation of a new profession; (c) The raising of standards in the field unless this is consistent with the realities of mobility instruction; or (d) Attracting and training recruits who by reason of their own dynamic creativeness may not remain in mobility instruction for a reasonable period of time.

In the face of the questions raised in this paper, what constructive steps can be taken now?

1. The need for mobility instruction is crucial right now. Within the narrow framework of the subject matter and skills of mobility instruction, short-term training programs should be conducted all over the country to meet the immediate need. These programs will up-grade existing trainers, orient new trainers, and begin to provide mobility instruction to multifaceted professional individuals. In many agencies, the need for foot-travel instruction is limited to a part-time function. Realistically, the worker with other skills may be assigned mobility training functions and should be prepared to undertake them.

Obviously, this is a short-term expedient. However, the long-term solutions will come more slowly. We cannot help but be concerned with the immediate needs of blind persons, and only secondarily with our feelings about the nature of mobility instruction as a profession or a field of work.

2. There should be an immediate consideration of launching a full-scale investigation of mobility. So little is known about mobility itself that it seems premature to establish formalized training until the field takes on a more concrete body of knowledge. For example, the pioneer work performed by Dallenbach, Cotzin, Worchel, and others relating to the use of hearing as a crucial factor in mobility has been applied to everyday mobility service to a slight degree. There is currently no systematized method of training blind persons in the use of hearing cues in the environment, the detection of obstacles through sound, and the enhancement of the usefulness of hearing acuity. Without these vital data, are we prepared to say that we have a suitable body of subject matter?

3. Studies should be made of the function of mobility instruction and of those who do the instructing. Based upon sound job analysis principles, a study should be made of the functions of the mobility instructor and the competencies required to do the job. Furthermore, attempts should be made to study successful mobility instructors from a psychosocial point of view to identify the characteristics which seem essential to the adequate performance of the function.

4. On the basis of these data, a well-organized curriculum study should be launched involving not only specialists in mobility instruction, but also specialists in curriculum construction and professiona

training. Such a study would be performed by the extensive facilities offered by a number of universities which train specialists in university and professional curriculum. However, attempts should be made to have specialists in service to the blind participate in order to avoid some of the gross errors that have been made in such research by investigators whose contacts with the special problems of blindness have been minimal.

In the absence of the data required to formulate curriculum, it is difficult to suggest the directions in which such a curriculum will move. However, it seems evident that one promising alternative is to make mobility instruction a function of a larger and more comprehensive occupation. Physical, corrective, and occupational therapy offer promising leads as fields into which mobility instruction may be incorporated. In this way, rehabilitation centers and agencies for the blind would be able to use the broader skills of these professions as well as the specialized techniques of mobility instruction which would become integral parts of the training in these fields.

III. Orientation and Mobility in the Vocational Area

IRVING J. KRUGER

SOMEONE ONCE SAID that freedom is not something one must grope for—always beyond reach—but that freedom is within and can be developed. In the case of blindness, orientation is a means to that freedom. The ability to move about and an awareness of the immediate environment are essential factors in making a life and making a living. Freedom of movement in many cases does more for self-respect than the job itself.

One definition of orientation, among many, is the knowing and controlling of the body in relationship to the environment. This definition must be broadened to include a relearning of "where I am, what I am doing, and where I am going" in relation to places, things or other persons. We should also consider the term "reorientation" because of the number of the adventitious blind we serve.

Immobility is a breeder of stagnation whether it be physical or mental. Mobility has been defined synonymous with life itself. St. Thomas defined a living being as one that could move itself. If a part of the human anatomy lacks movement (function) some other life process suffers. The non-functioning part can be removed and we can accept the consequence of enduring any future complications or we may have the choice of undergoing long training and try to compensate for the loss of function by a vicarious transfer of the work to another part of the anatomy.

In recognizing that multiple disabilities sometimes restrict mobility we must recognize that we can have a limitation of physical mobility but continue to have an active dynamic mental functioning. This, in part, explains the achievements of many wheelchair and bedridden individuals. However, mobility without an awareness of the immediate environment carries with it inherent limitations. On the other hand, having an awareness of the immediate environment and not having the skills and desires to be mobile also effects severe limitations. Orientation and mobility offer the same

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degree of security that a sighted person gains from the use of his vision. We should note that orientation and mobility are not necessarily products of the rehabilitation sequence, especially because the latter is contingent upon many personal factors, e.g., initiative, motivation, courage, ability, and others. The individual might be brought to the final stage of the rehabilitation process, that is, have acquired the techniques, skills and knowledge necessary to become more mobile, but yet not be sufficiently motivated or interested to utilize the training profitably. The utilization of any medium (cane, dog, sighted guide) toward safe, more efficient movement should only be evaluated in terms of the performance and the satisfaction of the individual.

When the client has been trained or retrained to utilize other senses and talents; to use strange but necessary tools; when he has acquired the basic skills of orientation and mobility; when he has recognized and accepted his blindness and its limitations; and when he has learned that he differs from a sighted person only by the loss of vision, it would appear then that the client has shown the growth necessary to begin his return to his place in society.

If the conflicts produced by the disruption and disorientation of patterns of daily living have somewhat been resolved, we must then begin to evaluate the client's potentials and think of practical goals such as possible employment in competitive industry, vending stands, homemaking, professional levels, sheltered workshops and perhaps some type of homebound employment or other related areas.

If a picture is worth a thousand words, then the opportunity to examine tactually by a blind person is surely worth at least a like amount. Sighted people often experience considerable difficulty in following a road map of highway markers, but after having driven through an unfamiliar area once or twice (actually orientation to the route) they are then able to make the trip with a minimum of trouble. Rarely are sighted people capable of giving directions to a blind person without creating confusion and apprehension. It follows, therefore, that orientation and mobility must be taught by trained and experienced instructors. Experience has shown that some blind persons are able to realize an awareness of a situation by a verbal or written description, while others find it essential to examine tactually in order to gain a comparable "picture" of the same thing.

Goals in Vocational Terms

In the broadest vocational sense blindness is an impairment imposing unique limitations in various degrees which may be either handicapping, disabling or both. How disabling? How much of a handicap? Is our client receptive to the idea that someone else in a similar situation was able to help himself? Has the acquisition of these newly acquired skills begun to allay fears that he might not return to his position in the family? Can he function with the minimal amount of assistance? Was there any value in spending months of anxiety, apprehension, and hard work in acquiring these skills? Accordingly, we must consider the specific goals and individual needs. And so, among other things, our program should prepare the client for:

1. Traveling to and from a vocational area, including what to do when a car pool breaks up thus necessitating a change of conveyance; braving the elements; use of a phone to report reason for delay.

2. A change of the work environment, including movement of the work area to another part of the building or to another city; a change in the place of tools, material, benches, appliances.

3. Handling challenges imposed by distractions and interruptions, including noise; confusion; work area crowded by material or personnel; operation sequence disrupted by communications from superior; fire drills. At home, the telephone and front doorbell ringing at the same time.

4. Conforming with the disciplines and

demands of the organization; loyalty and cooperation; getting along with fellow employees and customers.

5. Handling the demands of daily living, including being able to determine when and how to ask for directions, or the location of an office, a room, or desk, for example.

6. Recognizing that moving about freely brings about inherent hazards (cuts, bruises, etc.) and being able to cope with these and related situations. Being able to stop quickly or "freeze" when so ordered or being able to move instantly if indicated.

Such a program of orientation and mobility could be the means by which later adjustments may be realized, thus preparing the client for future stresses, hazards and embarrassments.

Attuning the above program to any of the "world of work" areas would not be difficult. For example, let us consider the homemaker. She may desire to shop at a neighborhood store and, if oriented properly and with intelligent application of the skills learned, should be prepared to board a bus and, if the need arises, to return by some other means, i.e., taxi, subway, etc. This person should have been oriented to handle the problem of taking an alternate route if required and not to become overdistressed if she finds herself on the wrong bus, if she gets off at the wrong stop or finds that she has been given incorrect directions. She should be prepared to cope with the pushing and jostling of the crowds and be aware of such embarrassing comments as "What's a blind woman doing downtown alone." Our homemaker should have been oriented to acceptable shopping procedure, to make and count change, and to realize that many salespeople are not trained to adequately describe articles to a blind person. In short, the homemaker should be able to display as much poise and dignity as the situation demands.

A program of orientation and mobility actually should equip a person to do for himself all the things that he could do if he were not blind. Recognizing the limitations imposed by a disability, we must realize that for many the reaching of an average level is the great achievement. The blind person wants more than almost anything else to be considered normal and average, and the fewer special appliances, gadgets or devices used, the better the rehabilitation job that can be done. Specific aids have been developed which are essential to equalize the blind person's performance with that of the sighted, yet these should be kept at a minimum and be considered only if there is no alternative.

Orientation to the physical and organizational structure is essential. This consideration is not unique to blindness, but rather, is a logical procedure used throughout the economic world. A thorough acquaintance with the plant layout, location of areas of need and concern, and some knowledge of the management operations would indicate interest of the worker who often gives more of himself than the job requires and thus builds strong ties of loyalty to his employer.

Reorientation Facilities Frequently Lacking

One area most often neglected or overlooked is reorientation. For some reason a blind worker has not had the opportunity or the need to move about in a particular area (shop, locality) or to use a particular tool or utensil, and abruptly a situation demands a knowledge of these things. Facilities for reorientation should be offered where a qualified need exists. I do not imply or suggest that the orientor be available for every whim that may arise.

In a training center the use of any practical means geared toward general orientation should be employed. As an exercise the drill press could be used for orientation training and to develop concepts for some future application in another situation. For example:

1. Learning the location of the drill press in relationship to other machines.

2. Learning the position of the stationary and moving parts.

3. Learning the safety principles and their applications.

4. Learning to coordinate the movements of the hands; also how to increase work tolerance and capacity.

5. Learning efficient and smooth operation.

6. Learning good housekeeping principles—to keep the machine and area clean and cleared from obstruction.

7. Learning maintenance and repair of equipment.

A sociologist might term such training as practice for "future role," but we like to believe that our orientation training is preparation for life in general.

I have tried to avoid overlapping the vocational implications of orientation and mobility from the personal and social areas. Originally, I felt it was almost impossible to separate orientation and mobility into specific areas. And now that my talk is about to conclude I do not know whether any degree of delineation has resulted. However, the rationale in teaching mobility skills and the development of adequate orientation should always be directed toward the abilities, needs, goals and motivation of the individual. It is the client who accomplishes, who does the achieving—all we do is offer a little direction.

Finally, the orientor's work must be evaluated. He must be mindful of those who fail, for each time a client fails a careful and critical analysis and appraisal of the orientor is in order. An inventory of the instructor's insight, patience, attitudes and methods must be made. The successful results do not offer the luxury of self-satisfaction or complacency on the part of the instructor because no one in this work should ever take the position of having all the answers. The clients who succeed in realizing their orientation and mobility goals do so by virtue of their ability and determination, not because of a "golden formula."

IV. Orientation and Mobility for Blind Children

ROBERT H. WHITSTOCK

THERE ARE NO SIMPLE solutions to the problems of orientation and mobility for blind children. Children, whether blind or sighted, are individuals, and efforts to guide their behavioral development should be tailored to fit their individual needs, capacities, interests, and circumstances. As a consequence, imagination, a constructive attitude toward blindness, and an understanding of human behavior are of more value to a teacher than a manual of procedures on mobility technique. Because orientation and mobility considerations reach to the core of human personality and development, school and home must coordinate their efforts in order to achieve maximum results. Such efforts should be directed toward engendering within the individual the motivation to participate in purposeful activity. At the same time, the child should be encouraged to develop an accumulation of skills appropriate to his progressive interaction with his widening physical and social environment.

The ideal situation is to create a social-cultural climate in which the individual will react as a whole person, and thus develop within himself maximum use of his inherent potentialities. To strive effectively

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toward such a result would require the joint effort and cooperation of all those who come in contact with the maturing child. Attitudes cannot be formally taught, but their influence upon the self-image of a child is enormous. Consequently, parents and teachers alike should be guided in understanding themselves and their attitudes toward a blind child. This can be facilitated through counseling, group discussion, and a familiarity with the formalized information available on blindness and its implications.

For the purposes of subsequent discussion, a distinction—artificial though it is—will be drawn between orientation and mobility. By orientation I mean an effective awareness of and interaction by an individual with his physical, cultural and social environment. By mobility I mean the possession or use by an individual of formalized skills for his independent negotiation of the physical environment.

Orientation by the above definition begins with infancy. It begins with the vague, generalized gestures of a newborn and in the infant's response to the love and encouragement of those around him. Through processes of socialization and maturation, the infant slowly develops into a distinct human entity within the social fabric of the family. The child's behavior and self-image reflect in large measure the influences brought to bear by those with whom he comes in contact. Rejection or over-protection can retard, smother, or distort aspects of behavioral development to so great an extent that their effects may never be wholly erased. At all levels of a child's development he needs opportunity to learn, to explore, and to experience. Also important in the process of behavioral development is the impact of acceptance, encouragement to activity, and realistic thinking by the family.

It should be apparent from the foregoing that the same principles and procedures which orient sighted children to their surroundings apply equally to the orientation of blind children. A child, in order to maximize his awareness of and participation in his social and physical environment, must be given as many meaningful experiences as possible. He should go to the zoo, the park, the museum, for example, and should be encouraged to interact with other children. A blind child should be given family and school responsibilities commensurate with his capacity and development. His interest in hobbies should be fostered, and he should be encouraged to participate in sports so that coordination and balance will be improved. Bumps and bruises are the fare of all active children, and certainly teach self-reliance and realism, while over-protection encourages dependence and unreasonable fear.

Teachers and parents should act jointly to instill in a child self-confidence, self-respect and an independent spirit. Bad posture and "blindisms," such as rocking back and forth while sitting or standing, set a blind child apart as "different" and should be discouraged. How to correct them will depend upon the make-up of the individual child. Blind children should be given as much freedom as possible and as much contact with sighted persons, both children and adults, as circumstances will permit, through games, parties, clubs and the like. From these experiences and from this interaction, the blind child will develop a more realistic appraisal of himself and his role, for he will become increasingly aware of his strengths and weaknesses.

When a blind child enrolls in a class he should be shown the location of his seat, and should be encouraged to find it himself subsequently. He should be directed to locations—rather than led to them—where such a procedure is feasible. If specific circumstances make it mandatory for a child to be led by someone else, he should hold his guide's elbow lightly, using the contact for guidance only, not for support. Also, the child should be encouraged to familiarize himself with the physical layout and structure of his surroundings. For example, he should be permitted to study the out-

lines of a truck, rather than have it described to him, so that he will have a clear mental picture of the dimensions and appearance of a truck.

A fundamental principle in the orientation guidance of a blind child is to teach him to act in such a manner as to maximize his social acceptability by others. Thus, he should be taught to use such everyday phrases as "did you watch television?" He should be taught to turn toward the person to whom he is speaking, not with the idea of teaching him to try to pretend he is not blind, but so that he will not deviate from accepted patterns of communication among people. When in a darkened room, he should turn on the light so as not to startle others who might enter the room. Neatness in appearance and proper table etiquette should be expected and required of a blind child, for there is no reason why, with proper instruction, he cannot master both.

Non-visual Cues

There are an infinite number of non-visual contacts a blind person has with his environment which furnish valuable information about the nature of his surroundings. These cues, or contacts, are utilized by the blind person to a highly differentiated extent. If properly utilized, they provide a wealth of meaningful experience, and facilitate an individual's ability to move about with freedom and confidence. A teacher can acquire an awareness of these cues through imagination and observation. If this is done, the teacher will then be able to assist a blind child to become more "cue-conscious." Of course, a blind person does not have a "sixth sense," but he can develop his remaining senses to a high degree in order to compensate for his visual impairment. The following are a few non-visual cues which can provide a person with helpful information. They are illustrative only.

1. A bakery has a characteristic odor which serves to locate it as a landmark, or informs the blind person of its purpose.

2. A trolley has a sound all its own. This sound identifies the street as a major thoroughfare, or points out the location of a possible means of transportation.

3. The heat of the sun can tell a blind person whether the day is clear, and locate direction, such as east or west.

4. The wind can give a great deal of information: it rustles through leaves, and sighs through pine branches. If constant, it can give a method of checking one's direction. If a person steps past the protection of a building, its unchecked gust identifies an open space adjacent to him.

5. A driveway can act as a landmark and can be distinguished as a break in the sidewalk, or a gravel strip through concrete.

6. Echoes and sound reverberations tell a discriminating ear much about the nature of the surroundings; for example, it is generally possible to tell whether a room is large or small, by sound.

7. There is a difference in resiliency and sound in walking on different surfaces, such as on a rug, grass, concrete or wooden floors.

8. There is a change in sound when you walk down a corridor and pass an open door.

9. The movement of traffic indicates through sound whether or not the light is in your favor.

10. Traffic lights often click or buzz softly just before changing.

11. Plastic, wood and metal have different textures to the touch and make different sounds.

12. Sounds coming from outside through an open window point out the location of the window, as well as indicating to the blind person that the window is open.

13. Tree trunks, poles or other large objects give back faint echoes which can identify landmarks or prevent collision. This ability is often called "obstacle perception" and is possessed by blind persons to a widely differing degree.

An increased awareness by a blind child of these cues will enrich his participation

in his surroundings, as well as aid him later in utilizing formalized travel techniques. A child's later mobility training can also be more effective if he learns to gauge distance by sound and develops good muscular coordination and balance. At an early age the ability to gauge distance by sound can be increased through games; for example, throwing a ball or pitching horseshoes at a sound could be helpful, as well as practicing the recovery of fallen objects by the sound they make when they strike the floor or ground. Agility, coordination and balance can be improved through swimming—or merely hiking across an open field without holding someone's arm.

These suggestions are illustrative and are not meant as rules, for each child is an individual and the method which best meets his needs and interests must be tailored to fit him as an individual.

Freedom of choice as to which system of mobility a blind person will use in adulthood should be a fundamental concept in rehabilitation, for the ability to make decisions is a necessary component in successful personal adjustment. However, realistic decisions can only be made where accurate facts are at the individual's disposal; consequently, within the process of educating a blind child, accurate information about various systems of mobility should be made available to him. The individual can then decide which system best serves his needs. Also, it is accepted rehabilitation doctrine that blind persons traveling in the general community should make use of a formalized mobility aid in order to increase safety, acquire true independence and avoid inconvenience and danger to others. A properly used mobility aid diminishes adverse public reaction and reduces the nervous tension involved in travel.

As a consequence, blind children should be encouraged to think in a positive vein, and at an early age, about mobility aid considerations—cane and dog guide. A child should not be forced prematurely into such training, for this can create mental blocks which may impair future independence. If any yardstick is appropriate, it would probably be the following: first, the level of orientation should be such that the individual is capable of learning the technique effectively; and second, he should possess the necessary development in social participation and motivation to utilize the acquired skill. If he lacks either an appropriate level of orientation or the impetus to make use of travel training, any attempt at travel instruction will be futile, and the child may well become disillusioned about his ability to become independent.

Selection of Travel Technique

Since individual needs are so complex and since so many factors enter into the mobility aid which best serves the individual, it behooves those entrusted with the guidance of blind persons to discard their personal prejudice for a particular mobility aid. As a practical matter, thorough training for the use of either the cane or the dog guide generally equips the individual to reach higher levels of effectiveness in the alternate technique. Both are tried and proven methods which serve to acquaint blind persons with valuable travel information, and also contribute immeasurably to safety and efficiency in negotiating the physical environment. It becomes the responsibility, therefore, of those who counsel individual blind persons to remain impartial when assisting the individual to arrive at a sound choice as to which mobility technique will bring the highest development to the individual's total personality. For a child to be able to make a wise decision in adulthood, it is important that accurate information about dog guides—as well as cane technique—be included as an integral part of his travel instruction.

With the foregoing discussion as a frame of reference, it is now possible to discuss The Seeing Eye program as it directly relates to the subject of orientation and mobility for blind children.

Sixteen is the minimum age for appli-

cants to Seeing Eye. Experience has indicated that children younger than this generally lack the necessary judgment and sense of responsibility to make proper use of a dog guide. The Seeing Eye judges each applicant on his individual merits. Not all blind persons can, or should, work with dog guides, but for those who do meet the necessary standards, a Seeing Eye dog can provide an extremely safe, rapid, and highly efficient system of travel. Degree of vision, temperament, mental and physical fitness, plus a constructive purpose in life —all are important considerations.

Blind persons have come to The Seeing Eye from every part of the United States. They represent every station in life—including ministers, public officials, factory workers, farmers, teachers, professors, business executives, housewives, and students, just to mention a few. Individualized treatment and training play an important part in the program which is designed to give the individual the opportunity to maintain his dignity and self-respect, and to build self-reliance. Guidance in personal adjustment is also available. The contact a new student has in the training course with successful blind persons who have returned for replacement dogs provides excellent examples of the freedom and independence possible for themselves.

Students are asked to share in the cost of their adjustment to a Seeing Eye dog. The amount represents only a fraction of the actual cost of the training—one hundred and fifty dollars for the adjustment with the first dog, and fifty dollars for any subsequent dog. This amount also includes room and board, the dog's equipment, and the tuition. The student may pay as little as a dollar down and a dollar a month for as many years as is necessary to complete the obligation. Seeing Eye also will advance transportation costs, with the understanding that only fifty dollars of this amount will be repaid to The Seeing Eye whenever it is convenient. The reasons underlying this financial policy are rooted in Seeing Eye philosophy.

The self-respecting blind person, like anyone else, desires the chance to be accepted by society on an equal basis. Such acceptance cannot be won through constant charity; therefore, his payment is for his own self-respect. Furthermore, it gives to the public tangible evidence of the willingness and capacity of a blind person to accept financial responsibility. From the rehabilitation viewpoint, a person who shares in the cost of his training will appreciate and value his dog guide much more.

The course at The Seeing Eye generally lasts four weeks, depending on individual progress. At the beginning of the training period, dog and master are matched according to personality and size. Before the dog guide is turned over to its new master it has passed through the processes of being screened for suitability and has been thoroughly trained and tested. The course is carried on under actual—not simulated —travel conditions, beginning with quiet residential areas and terminating in complicated travel situations. In addition, instruction is given in the care and control of a Seeing Eye dog, as well as in the way a dog guide can be left alone when circumstances warrant it.

At the conclusion of the course, master will return with his dog to his home community to participate in a sighted world in accordance with his ability and motivation. The extent of this participation and the effectiveness with which he will take advantage of his new-found freedom will depend in large measure on himself. The higher his previous level of orientation and the stronger his previous motivation toward activity, the more successful will be his efforts. This fact is as true for a blind person who has chosen cane travel as it is for one who prefers mobility through a dog guide. Consequently, orientation and mobility consideration should be given early attention in the development of a blind child, so that, as an adult, he can achieve maximum effectiveness, socially and economically.

Culture as an Aspect of the Total Personality

WILLIAM V. GIOSEFFI

This article has validity for our field since blind people represent a cross section of the varied cultural groups that make up America. It is important for practitioners to understand the mores, folkways and social institutions of the people they serve. What variations in reaction to blindness may be expected from individuals who have roots in Puerto Rico, or Poland or China, or Mexico or Ireland?

More provocative is the question: Do "the blind" constitute a subculture in our society? A subculture has been described as follows: "Every society is internally differentiated into numerous subgroups, each with ways of thinking and doing that are in some respects peculiarly its own, that one can acquire only by participating in these subgroups and that one can scarcely help acquiring if he is a full-fledged participant."

Would it then follow that blind persons who, in their employment or in their social activities, are associated almost exclusively with other persons who are blind do tend to become members of a subculture?

AN AWARENESS OF CULTURE is not new to the profession of social work. The heterogeneous nature of American society has long forced us to recognize the differences in ethnic groups. As individual social workers, therefore, we have learned a good deal about varying folkways, mores, beliefs, and social institutions. We have described what we have observed in our practice in conferences, in articles for publication, and in group discussions. However, we have not recorded our observations in sufficient detail nor have we systematized this body of knowledge for the purpose of transmitting it to others.

We have not always understood, in terms of their cultural conditioning, the facts we have described. For example, a worker may have observed and recorded the fact that an Italian artisan obtained more satisfaction from his craftsmanship than from achieving financial success by employing it. Rarely, however, has he discerned the various implications of this knowledge or used it diagnostically or therapeutically when the artisan's unhappy "Americanized" son revolted against the

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consequent standard of living provided by his father.

Only recently have social workers come to understand the way in which culture modifies individual roles in family living. We have had to rely on the social scientist, who has developed a more systematic and dynamic approach to cultural material. Social scientists are technically equipped to engage in the painstaking research necessary to collect, sift, and organize cultural observations into a meaningful whole. Social workers, however, need to find a way of integrating their knowledge and awareness of cultural factors within the framework of their own conceptualizations so that these factors become a usable part of social work's knowledge about human relations—as dynamic a part as are psychological factors.

Personality Development and Cultural Patterns

The current emphasis on the family as the unit for diagnosis and treatment in casework is causing us to observe more systematically the interactions among the members of this small group. Each member is seen as playing his own role in the drama of the family in such a way that a pattern or style for that family's total behavior emerges from the interactions of the various members. What is not always understood is that the cultural expectations of the larger social groups in which the family finds itself must of necessity play a significant part in determining not only the actions and interactions of each member, but also the major characteristics of the family picture. The particular way in which each member of the family has learned the roles taught by the cultural group of which the family is a part will affect his own personality pattern, the pattern of the family as a unit, and eventually the pattern of the group as a cultural entity. It is this reciprocity between the individual personality and the cultural group which we need to study further if we are to gain deeper knowledge of human behavior and wider perspective in social work practice.

Examining how a human being becomes the embodiment and representative of a culture enables us to understand the interdependence of personality development and cultural patterns. The development of the individual from infancy to the status of an adult member of his group can be viewed as the process of acculturation, that is, the process through which the individual becomes a social being. This process entails the integration of the biological, psychological, and sociocultural aspects of the individual's development. It is the process by which personality is formed out of the individual's experiences and relationships with people of a given culture. The science of human relations is the theoretical and practical study of this process.

The human organism can develop its potentialities for a full and rounded life only through its living with others. A young child is dependent for his very life, as he was indeed in the womb, upon the world about him. He grows to relative independence and acquires an identity as a mature person by a continuing process of interaction with his environment. The human being can never accomplish this alone —as it were, in a vacuum. He must have air to breathe, food to assimilate, protection from the elements, and people to provide care. He must have intimate contacts with life and freedom to exercise these contacts within the limits of reality. For the rest of his life he will deal with these same preoccupations. How the individual manages to meet his needs and what patterns he will begin to develop for maintaining the ensuing satisfactions depend on what the people around him think, believe, fear, and feel.

The impact of others on the individual begins with the mothering person and persists with family friends, teachers, employers, and all those with whom he comes in contact in his daily living. From birth, these outside forces shape his patterns for meeting each successive new experience,

each new need or situation. Like the rural Italian baby, he may be kept tight in swaddling clothes so that the satisfaction of every physical need becomes a tremendous effort—one about which he can become annoyed—with the result that eventually he will develop a pattern of rage in his subsequent encounters with restrictions. His feeding may be determined by arbitrary rules of his people, which may or may not meet his needs, as we have seen at times in our own society. He may be picked up or he may be left to cry, depending on what virtue is to be inculcated. As he begins to explore his body, food, and eventually all the things about him, he may experience a sense of freedom in making discoveries and in learning or he may immediately become inhibited by mores about cleanliness and dirtiness, physically and symbolically speaking. How will he begin to perceive and compose in his mind the personification of a mother? Is it to be composed of a combination of two mothering persons, as may be true in the subgroup of the American career woman or where grandmothers still play a mothering role?

These are some of the ways by which the child achieves, through an exposure to the beliefs, attitudes, and habits common to his group, an early notion of people as good and bad, giving and withholding. Later he must also learn from his world the various roles expected of him with regard to sexual identifications, marriage, parenthood, education, and work, and the myriad responsibilities or relationships called for by the particular complexity of his culture.

Cultural Conditioning

The individual's potential for living is thus developed, thwarted, or biased in one direction or another by the accepted mores and beliefs of his group; for the members of his group are the carriers of the culture of his society and they are bound by the very structure of the group to inculcate their values in him. This process of socialization involves the cultural conditioning of his earliest biological needs and determines the acceptable ways in which he may satisfy them. Moreover, this learning from and through his group takes place in relation not only to his basic physical needs, but also to his emotional and spiritual needs. It is thus that he experiences tenderness, through which he may develop genuine feeling; a sense of achievement, which will give him a sense of power; a feeling of belonging to, and acceptance by, a group, which enhances his sense of identity; the capacity for intimacy with members of the same sex, which will give him friendship; and later, intimacy with the opposite sex, which will complete his heterosexual adjustment. The patterns of behavior he develops for achieving the satisfactions of these needs will determine his security in life. These individual patterns will be fashioned, however, out of the basic patterns his society permits and agrees upon. This is the meaning of a transmitted and learned culture.

This learning process evolves more from experience than from instruction. Values are transmitted mainly through the attitudes of the adults who are close to the child. As he integrates his various experiences in the light of and within the patterns of his already developing personality, the child makes his own unique interpretation of the values his group tries to teach him, which will be similar to those of his mentors yet will be experienced differently by him according to his own particular situation. They thus become a unique part of him, a true ingredient of his personality.

Culture is not added to or superimposed upon a personality; it is integrated. Furthermore, the individual is not exposed to culture as an abstraction or a generalization devised by the anthropologist but rather to culture as those about him have accepted, felt, possessed, and then transmitted it. So the child grows up with a culture composed of what others about him think it is and what he himself makes of what they think it is—that is, as it is experienced by him. One's culture in this sense is generated by each new child—a

precious creation of his own which has necessarily undergone some change in the process of transmittal. It is, therefore, not so much that the culture holds him as that he now holds the culture. He is in the culture (a concept) and the culture is in him (a fact and a reality). Moreover, he sees and understands the world through the culture of his own society as he has integrated it. He has now learned to interpret the present and to anticipate the future in terms of the past—a past composed of enduring patterns which he shares with others of his cultural group.

It is because one's culture is internalized that social change is resisted. Social change threatens less the structure that is outside the person than that which is integrated within him; that is, it threatens his security. A client may resist change not only when it involves intrapsychic defenses, but also when it involves an action or a belief which may never have been permitted by his group and is, therefore, unacceptable to him. The very consideration of making such a change is, therefore, productive of anxiety—and anxiety is the red flag that warns him to protect his set of patterns. Even if one has perchance rejected his group and its outward mores, he cannot as easily reject the values that are internalized and have become enduring patterns by which he guards his security. The American-born child of immigrants often has such a problem. He may be in conflict with his family and reject the traditions that are symbolic of his parents, but later, when he marries, he may adopt the same attitudes in his roles of husband and father which he had earlier rejected in his own father.

A person who has left one cultural region for another finds it hard to assimilate or be assimilated because of such collective learned ways of behavior. Even when his values are not reinforced by social pressure (as they usually are when he lives among other immigrants), he feels the need to maintain cultural patterns that have been comfortable and secure for him. The social worker's appreciation of this need on the client's part would help the worker identify with the client, accept him as he is, and realize that he must support his efforts to find other securities and ways of satisfying needs before he can consider a modification of values learned in another cultural setting. Sometimes he can be helped only when professional services are geared to his cultural ways of taking help and tend to maintain his own set of securities. It must also be remembered that an interview between client and worker may often represent a cultral conflict when they come from different cultures or subgroups. It becomes the worker's responsibility to develop an awareness of his own cultural patterns and values so that he can deal with the cultural, as well as the psychological, interactions in the interview. This kind of awareness may help to make the contact an experience in acculturation and, therefore, may promote the client's total adjustment.

Misconceptions

I have discussed some aspects of culture as it is formed and as it helps to form a total personality. I should like now to examine some misconceptions about it. One such misconception is that cultural formulations are stereotypes to be avoided in the effort to individualize the client. The fear of stereotyping the client applies also to the use of psychological concepts, for example, using the concepts of anal, oral, or phallic patterns to explain all behavior. Stereotypes must be used in any science if it is to develop any formulations. The danger lies in using them arbitrarily. Like any generalizations, stereotypes are necessary to the development and transmission of theories. Eventually they must be applied in a flexible and individualized manner in some art or field of practice. For therapeutic purposes, it may be useful to have a working generalization that dependency patterns are related to disturbances at an oral stage of development. It may be equally useful to know that some correla-

tion has been found between dependency tendencies in Italian boys and cultural tendencies on the part of their mothers to minimize overt affectional expression toward male children and also to withdraw affection for the purposes of control and discipline.

Moreover, it is characteristic of anthropology that it discerns variations within a pattern according to locale, subgroup, age, sex, and so on and describes the multiple differentiations that actually exist within the patterns. For example, the Italian father in rural southern Italy may be more authoritative than the father in northern urban Italy. The northern Italian is also less controlling of his wife's and daughter's outside activities. The father's basic role, while similar in the two regions, is further differentiated by other factors, such as economic status and education. Moreover, the use an individual makes of his culture pattern further defines him as normal or neurotic. The recognition of these numerous differentiations should help to reduce the risks of making generalizations.

The earlier dichotomy between the psychological and the social sciences may have led to the erroneous notion that there are two entirely separate ways of explaining behavior in any given situation—through the analysis of the psychogenic factors or through the cultural factors. This notion has led some persons to suspect that the adherents of culture theory intend to advocate a cultural approach to problems—a sort of cultural casework in which the worker diagnoses and treats cases according to cultural formulations or factors rather than psychogenic ones. This misconception arose because of the assumption that there were either purely instinctual, or purely culturally learned, ways of behaving; or that therapy was to be rooted in either the social or the psychological, rather than in the psychosocial. In most areas of disturbance, however, one finds such an admixture of psychological and cultural determinants that it is difficult to separate them clearly. It is only in abstract science that they are separated. Today there is evidence that even in the abstract social sciences, the two sets of determinants are being brought together in a more nearly unified and integrated interpretation of behavior.

Two Facts Overlooked

The underlying reason for these various misconceptions arises from forgetting two facts: that there is a basic difference between a science and an art; and that a true science of human relations has not yet been fully developed. Science is an abstraction. The scientist looks at material from the point of view of his own discipline and abstracts what he wants. The anthropologist looks at man's behavior and describes cultural patterns—the ways in which a group of persons relate to each other and solve their problems of adjustment. The theologian or the biologist concentrates on a particular aspect of man's behavior and his methods of adjustment. Social work, on the other hand, is an art. Hence, the social worker must deal with the solution of a human problem by drawing upon the knowledge of as many other fields as may be necessary to accomplish his professionally established goals. Like all arts, social work's fund of knowledge includes data from many fields of inquiry. It has been well said that the professional use of the sciences is an act of synthesis, for it is in the practice of a professional art that the various knowledges can perhaps again become integrated. It is also in the realm of art that theories are tested and areas for exploration and clarification are developed.

Social work has a special responsibility, as well as an opportunity, for helping to promote a synthesis in the field of human behavior, because it has always enjoyed the special characteristic of treating the total person in the total situation. It is the social worker's recognition of the complexity of the individual as an interacting member of his family and his society that makes him a primary contributor to the young but growing science of human relations.

On the Unreality of Words to the Blind

CARSON Y. NOLAN, Ph.D.

IN DISCUSSING READING readiness, Tinker[4] states that "only when printed symbols stand for words used meaningfully in his own speech is the child ready to read successfully." Inability to gain realistic meanings for words symbolizing objects or concepts not directly accessible through auditory or tactual channels may impede learning reading for blind children. The only empirical evidence available concerning realism of verbal concepts used by blind children is contained in a study made by Cutsforth[1] three decades ago.

In this study, Cutsforth, using a form of controlled association, required blind children to respond to a list of stimulus words. He found that 58 per cent of the responses of a group of twenty-six children described visual attributes of the stimulus word. A large number of the visual attributes mentioned were erroneous. In discussing these findings elsewhere, Cutsforth says, "A predisposition toward the unwarranted use of meaningless visual terminology demonstrates a strong tendency toward unreality in which valid relationships are utterly disregarded. The inevitable result is that nothing but incoherent and loose thinking is possible. Intellectually, the child is organized without reference either to himself or to his own experiential world. The seeing world with its visual concepts and values becomes the flimsy gossamer web out of which his intellectual fabric must be woven."[2] Cutsforth lays most of the responsibility for this problem at the feet of educators of the blind.

If Cutsforth's findings are valid, the implications of verbal unrealism for reading of blind children should be thoroughly investigated. Since these findings are based on a small number of children, and since educational methods may have changed in the past thirty years, it appeared advisable to reconfirm Cutsforth's findings. This paper is a description of the outcome of that effort.

Procedure

The procedure followed was that described by Cutsforth.[1] Individual children were required to respond orally to thirty-nine stimulus words (Table I) orally presented by the experimenter. A preliminary practice with ten obviously non-visual words was given. The instructions for controlled association were as follows: "There are lots of things you can say about everything. A man is tall or short, fat or slim, kind or mean. What would you say about _____?"

In order to determine if the controlled association method significantly affected the outcome, the study was replicated using a free association technique. Here the

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TABLE I

COMPARISON OF PROPORTIONS OF VISUAL RESPONSES GIVEN TO 39 STIMULUS WORDS BY CUTSFORTH'S GROUP, AND THE CONTROLLED AND FREE ASSOCIATION GROUPS OF THE PRESENT STUDY.

Word Stimulus	Per Cent of Visual Responses for Groups		
	Cutsforth	*Controlled*	*Free*
moon	.92	.44	.18
Indian	.91	.31	.13
handkerchief	.32	.25	.03
snow	.62	.33	.18
grass	.85	.71	.36
paper	.42	.06	.05
sky	.77	.53	.42
apple	.50	.17	.21
crow	.52	.20	.08
lemon	.15	0	.03
rose	.54	.28	.21
chalk	.81	.38	.15
violet	.70	.29	.18
pepper	.35	.06	.05
orange	.12	.06	.13
lily	.60	.13	.13
wool	.19	.03	.03
ivory	.30	0	.03
butter	.31	.06	.03
brick	.27	0	0
night	.96	.81	.37
carrot	.35	0	.10
cotton	.19	.11	.05
gold	.57	.20	.13
ink	.77	.25	.21
milk	.62	.06	.15
canary	.33	.20	.05
coal	.77	.47	.15
pumpkin	.36	.07	.08
robin	.54	.13	.08
tree	.31	.06	.08
blood	.85	.60	.28
brass	.25	.15	.05
star	.72	.44	.33
lamp	.77	.80	.64
plaster	.29	.03	0
tar	.62	.31	.13
tomato	.44	.19	.05
cherry	.63	.25	.13

instructions were: "There are lots of things you can say about everything. Now, when I say a word to you, I want you to say the first thing that pops into your mind."

Results for both methods were tabulated and two experimenters independently judged the number of visual responses given to each stimulus word. Perfect agreement on number of visual responses was obtained for 90 per cent of the stimulus words. Differences among judgments for the remaining 10 per cent were quite small.

The controlled association group included eight boys and eight girls who were totally blind or had light perception only. Twelve were blind from birth. Median grade for the group was six (range grades four to nine), and median age was thirteen years, ten months (range nine to sixteen years). The free association group included eighteen boys and twenty-one girls who were totally blind or had light perception only. The majority of these were blind from birth. Median grade for this group was seven (range grades four to twelve), and median age was fourteen years one month (range nine to twenty years).

Results

Table I gives the proportion of visual responses given to stimulus words for Cutsforth's group and the controlled and free association groups of the present study. Inspection reveals that the proportions of visual responses for both groups of the present study are much lower than those obtained by Cutsforth. Exceptions occur for several words such as grass, night, blood, and lamp. It is suggested that cultural verbal stereotypes such as blood-red or lamp-light may influence responses to these words. Proportions of visual responses for both groups of the present study appear quite similar for most words; however, for some words, the controlled association method appears to elicit more visual responses.

An over-all test was made to determine if the apparent differences among the three groups are real or the result of sampling error. A frequency distribution of proportions of visual responses to all stimulus words was made. These data are presented in Table II. Inspection of this table shows that both groups of the present study had much lower proportions of visual responses over-all. These data were used in a Kruskal-Wallis one-way analysis of variance by ranks[3] to determine whether these samples were from different populations. Results of this test showed no significant differences among the two groups of the study. However, both groups were significantly different from Cutsforth's group in the over-all amount of visual responses made. The

TABLE II

FREQUENCY DISTRIBUTIONS FOR PROPORTIONS OF VISUAL RESPONSES GIVEN TO 39 STIMULUS WORDS BY THREE GROUPS.

Per Cent of Visual Response	Groups		
	Cutsforth's N = 26	*Controlled Association* N = 16	*Free Association* N = 39
0–5		6	13
6–10		7	5
11–15	2	4	9
16–20	2	5	5
21–25	1	3	1
26–30	3	2	1
31–35	6	3	1
36–40	1	1	2
41–45	2	2	1
46–50	1	1	
51–55	3	1	
56–60	2	1	
61–65	4		1
66–70	1		
71–75	1	1	
76–80	4	2	
81–85	3		
86–90			
91–95	2		
96–100	1		

level of significance for this conclusion was such that chances for being in error were only 1 in 1000.

One additional bit of interesting evidence was available. For four words of the study, free associations were available[5] for 1000 sighted children. Proportions of visual responses to these four words made by this sighted group and the three blind groups are included in Table III. Comparison of these proportions indicates that the children studied closely resemble normally sighted children in amount of visual responses to the four stimulus words. However, responses of Cutsforth's children to three of the words are quite different from those of the other three groups.

TABLE III

A COMPARISON OF PROPORTIONS OF VISUAL RESPONSES TO FOUR STIMULUS WORDS GIVEN BY THREE BLIND GROUPS AND ONE SIGHTED GROUP.

Stimulus Word	Groups			
	Sighted	*Free Association*	*Controlled Association*	*Cutsforth*
milk	.09	.15	.06	.62
moon	.43	.18	.44	.92
butter	.12	.03	.06	.31
lamp	.67	.64	.80	.77

On the basis of the available evidence, it appears that the blind children studied are not characterized by "verbal unreality" to the extent of Cutsforth's children. In fact, evidence from responses to four words indicates that their behavior corresponds to that of normally sighted children. The reasons for these findings are not apparent from the data.

Summary

Free and controlled associative responses to thirty-nine stimulus words were elicited from groups of thirty-nine and sixteen blind children respectively. Proportions of visual responses to these words were compared to those earlier obtained by Cutsforth. Significantly fewer visual responses were made by children in this experiment. It was concluded that "verbal unreality" is not a significant problem for the groups studied.

BIBLIOGRAPHY

1. Cutsforth, T. D., "The Unreality of Words to the Blind." *Teacher's Forum*, Vol. 4, No. 5, May 1932. pp. 86-89.
2. Cutsforth, T. D., *The Blind in School and Society*. New York, American Foundation for the Blind, 1951. p. 69.
3. Siegel, S., *Nonparametric Statistics for the Behavioral Sciences*. New York, McGraw-Hill, 1956. 330 pp.
4. Tinker, M. A., *Teaching Elementary Reading*. New York, Appleton-Century-Crofts, 1952. p. 33.
5. Woodrow, H. and Lowell, Frances, "Children's Association Frequency Tables." *Psychological Monographs*, 1916, p. 97.

Editorially Speaking

The ideal of complete integration of blind people in the community encompasses many complex factors. Among the most important is the blind person's mastery of the problems of mobility and orientation. Mobility skills, vital to the personal well-being and independence of the blind individual, also help to open social and economic doors to him by destroying the damaging stereotype of the blind person as a lone figure awkwardly groping his way about.

The importance of these skills has been recognized for a long time by some rehabilitation workers and residential-school administrators, who have devoted study and effort to provide training in mobility and orientation. The Veterans Administration's development of new ideas about mobility, particularly about the use of the cane in the adjustment of blinded servicemen of World War II, gave great impetus to the interest in this aspect of rehabilitation of the civilian blind. Along related lines, this magazine recently published two accounts of research dealing with the role of hearing in rehabilitation of the blind. In one project the aim was to train blind persons to make greater use of the sense of hearing as a direct aid in orientation and mobility ("Training Hearing to Greater Usefulness," Fay-Tyler M. Norton, Ph.D., December 1959); in the other the experiments were designed to assist hard-of-hearing blind persons toward the same end ("Rehabilitating Blind Persons with Impaired Hearing," Moe Bergman, Ed.D., December 1959).

While a substantial body of experience has already been accumulated, much remains to be done in assessing the importance of this area and in finding the best methods of helping blind people to achieve proficiency in these skills. The publication of a symposium on the subject in this issue of the *New Outlook* will contribute to the advancement of knowledge in this area. This and other material already published, as well as instances of affirmative action to meet needs, is all evidence of the growing awareness that facile mobility and orientation are almost universally prerequisite to rehabilitation.

The *New Outlook* hopes that this symposium will not be considered the end of the discussion; rather, that discussion of many facets of the problem will be evoked, and that a variety of viewpoints will be expressed. Such exchange leads to better services for blind people.

A REMINDER

that the *New Outlook for the Blind*, with *Talking Book Topics* supplement, is now available on 16⅔-rpm records. It is published monthly except July and August, and released concurrently with the inkprint and braille editions.

Subscriptions to the recorded edition are $5.00 per year. Address orders to the *New Outlook for the Blind*, 15 West Sixteenth Street, New York 11, New York. Checks should be made payable to the American Foundation for the Blind, Inc.

Hindsight

by M. Robert Barnett

PRESCRIPTION FOR THE DOCTOR

"When you come right down to it," an ophthalmologist friend of mine said to me at a recent New York luncheon, "the average doctor among us seldom sees a blind case." He musingly reflected back over his practice as I began to reflect back over my experience as a patient. "Telling a man that he is permanently blind is hard to do," he continued, "and most of the doctors I know are like me. They don't really have to do it very often, and when it does occur you find that you really are at a loss as to what to say, do, or suggest. I admit that it bothers most of us to tell the hard truth, but we could do a better job of it if we had more training through experience —or perhaps more help from somebody like you. . . ."

I heard what he said and I knew what he meant. I was busy with my own thoughts, though, and I wanted to say, "And the somebodies like me can use more help from somebody like you." My thoughts went back a number of years to the medical "somebody" I knew best. . . .

It may sound trite, but when I awoke in the hospital that morning I didn't know where I was. Therefore, like a standard story script, I said to a rustling skirt and clanking bath basin near me, "Where am I?"

"You are in St. Vincent's Hospital," the voice above the rustle and clank said, "and what's more you are not to move, so hold still while I finish washing you."

I did not need to ask the next standard question of what had happened, thanks to the bandages pressing on my chest and abdomen. Gradually, memories of the pilfering expedition into the orange grove came back—the strange sensation of being shot, the bewildering brilliance of the flash of light in my eyes, the growing weakness and nausea. Even the ride in a police car with siren wailing returned, though hazily. But I did have more questions: "What day is it? Who are you? Can I have something to eat?" And then after these were answered by the nurse—whom I shall evermore thank for handling me the way she did—there came the standard cliff-hanger: "Why are all these bandages on my head and face? Did I get hit in the eyes too?"

The nurse continued for a moment with a meticulous scrubbing of my right foot. "I am only your nurse, not your doctor," she said quietly. "I cannot answer all your questions, and he will be along very soon now. But, yes, your eyes have been injured."

"How long before they will take off the bandages?"

"I told you I am only your nurse—not your doctor. Let's try eating some breakfast now like a good boy."

The word "boy" was appropriate. All of this happened in 1932, and I was a fifteen-year-old high-school student. This put me then and would put me now in a very small statistical category of youthful blindness due to accident. I doubt whether my doctor—he became "my" doctor fortuitously, since he had been on duty in the hospital when I was brought into the emergency ward—had ever had a case just like me before. As my luncheon friend said, ". . . we don't see many cases of real blindness."

. . . "Well, Robert," the doctor said when he saw me awake and playing the game of "now-open-your-mouth-for-some-more-oatmeal" with the nurse, "you have come through the worst of it. You had us all a little worried for a time, but you're going to be fine." And to my repeated question about my eyes: "Well, now, you're going to have to be patient about that, but I would say that we'll have those

bandages off and you'll be as good as new in about two months." . . .

Twenty-seven years later and I am not "good as new"—that is, if he meant that my eyes would be, and that's just what he meant. There really was no proof for him at the time that he could not fix the eyes, and I have learned since then that no doctor will tell a patient "the worst" as long as there is the slightest chance of treatment or surgery. Besides, this particular physician was one of the country's top men in training and skill, and his medical judgment could be relied upon. In my case the prognosis already was hopeless by 50 per cent, because one eye had suffered the severance of the optic nerve. But the other eye still had its muscles and its nerve, and the doctor's optimism was based on the possibility of cutting away scar tissue to find, hopefully, an undamaged retina. It was not his fault that the hope never materialized.

It took two years for my doctor to reach a point of decision—decision that sight could not be restored. Second best, perhaps, but of vital importance to me, was his decision that young Robert had to get himself rehabilitated. He may not have had many like me, but he had learned enough to know at least some of the things I needed to be told.

It was he who told me about the school for the blind. It was he who overcame my initial horror—he who explained that it really was a school that would give me a normal education and not the asylum I always had thought it to be. . . . It was he who made the appointment for me to visit, and I am sure it was he who privately gave the school principal much-needed background about the new applicant. . . .

These thoughts brought me back to the subject at hand.

. . . "I was talking to one of your colleagues in a midwest city not long ago, Doctor," I said as I returned from the past to my coffee cup and the luncheon conversation. "This fellow also has patients in otolaryngology, and he told me that he doesn't have as much trouble in counseling deaf patients as he does his eye cases."

"I can well understand," said the doctor. "I'll bet he explained to you that his task of telling bad news is much easier with the deaf because of their own mental attitude."

And that, perhaps, sums it all up. That midwestern specialist said that the patient with serious hearing loss has little or no hesitancy to accept referral to a local hearing center, understanding that it is equipped to give specialized assistance of both technical and social service nature. On the other hand, almost none of his patients with severe visual loss or final blindness seem able to accept the idea of referral to an agency for the blind. We in this profession know all too well what these attitudes are, but try as we might, we are making very little if any progress in positive education.

Frequently we hear cries for more education of the public, and in this case, more education of the eye doctor. We expect him to make a social success of his medical failure—we prescribe for him a course of action that requires comprehension of a patient as a "whole person." And yet, we ourselves, all too often, are failing in giving the doctor as well as his patient the right prescription: demonstration through service that we are a vital and meaningful resource for all the people, and not a symbol of "charity" for the dependent, segregatable few.

It occurs to me that we tend to place eye doctors under a heavy burden of responsibility. We expect a great deal from a doctor, and well we might. We expect him to save vision even when we have done little to help save it ourselves through simple precautionary measures. We expect him to save vision even when medical science has not given him as yet any hint as to the cause of more than half of known eye disease. We expect him to reconstruct a damaged eye and prevent insidious infection even when the injury has left only the makings of a miracle. When he fails,

we expect him to break the news of blindness gently, to pump up the patient's morale, and guide him in the way he must continue to live.

Realistically, we might expect a degree of all this, but let's face it: very few patients find their "somebody" to be the combination doctor-social worker that mine was. Our specialized services somehow must break down psychological barriers and more effectively serve doctor as well as patient.

NSPB Elects President, Board Members

ENOS CURTIN, investment banker of New York City, was elected president of the National Society for the Prevention of Blindness at the Society's annual meeting in December. He succeeds Ira V. Hiscock, Sc.D., recently retired chairman of the Public Health Department at Yale University.

Mr. Curtin is president of the Ophthalmological Foundation and is a member of the board of the New York Association for the Blind. Among other activities, he was director of operations of the Marshall Plan and also served as a consultant for the National Production Authority, U. S. Department of Commerce, and the Defense Production Administration.

Other new members of the board of directors to serve for three years are: Mrs. Dorothy Bryan, assistant to the director, Division of Special Education—Blind and Partially Seeing, State Department of Public Instruction, Springfield, Illinois, and formerly director of services to the deaf-blind at the American Foundation for the Blind; Ralph E. Dwork, M.D., M.P.H., director of health, Ohio Department of Health, Columbus; Edward R. Granniss, manager, Loss Prevention and Engineering Department, Royal-Globe Insurance Group, New York City; Mrs. Ronald J. Foulis, chairman, Delta Gamma Fraternity Project on Sight Conservation and Aid to the Blind, Washington, D. C.; and Frank W. Newell, M.D., Department of Surgery, University of Chicago.

National Braille Press Offers Recording Service

REHABILITATION PERSONNEL may be interested to know that the National Braille Press, 88 St. Stephen Street, Boston 15, Massachusetts, is prepared to give immediate service in magnetic tape recording on request. Students and others will find this service valuable. Tape may be purchased from the Press. Recording is at either 3¾ or 7½ inches per second, as desired. All books should be directed to Mrs. Madeleine Jacobs at the above address. Names, addresses and telephone numbers are not to be affixed to a book itself; such information should be recorded on a three-by-five card and inserted in the book.

Conference on Services to Disturbed Blind Children

A CONFERENCE ON SERVICES to disturbed blind children will be held March 17-19 at the Kellogg Center for Continuing Education, Michigan State University, under the sponsorship of the American Foundation for the Blind.

The conference had its origins last summer at a workshop sponsored by the Foundation in cooperation with Northwestern University, at which a group of persons representing services to retarded blind children had an opportunity to discuss the problems and potentialities of these children with experts in the fields of medicine, psychiatry, education and social work. The same group has been invited to attend this month's conference, which was planned as a means of continuing this valuable exchange of information.

These meetings reflect a growing awareness of the challenge presented by children who have problems in addition to blindness. Many of these children have not been eligible for the existing educational resources in their states, or, having been accepted, have been found unable to participate in the programs as offered.

Michigan was selected for this year's meetings because it provided the opportunity to observe the program at the Michigan School for the Blind. Undismayed by the failure of some of the children to make the grade before, the school has not only re-examined and admitted some of them, but is also offering a program to others who could not function in the regular classroom. Here, in an atmosphere of understanding and with activities geared to their level of participation, these children are being found to be not only more communicative than originally assumed, but also ready to respond to appropriate educational techniques.

Participants in the conference will be administrators, psychologists, teachers, and social workers representing residential schools for the blind, public school programs and child welfare services.

Participants in July 1959 workshop, shown here, have been invited to attend conference. From left, clockwise: Dr. Jerome Cohen, associate professor, Northwestern University Medical School (workshop coordinator); Pauline M. Moor, program specialist, American Foundation for the Blind; Mrs. Mildred V. Tyler and Mrs. Eloise Cornelius, counselors, Illinois Department of Public Welfare, Preschool Blind Division; John SanFratello, teacher, New York State School for the Blind; Dr. Wan-Ho Chao Lee, clinical psychologist, Northwestern University Medical School; Joan B. Chase, teacher, New Jersey State Commission for the Blind; Mrs. Elinor Ring, coordinator, Blind Clinic, Children's Hospital of the District of Columbia; Sister Mary Janice, teacher, Most Holy Redeemer Day School for the Blind, Evergreen Park, Illinois; Mrs. Frances Culbertson, teacher, Tacoma, Washington; Mrs. Margaret Zerby, teacher, Michigan School for the Blind; Charles S. Napier, teacher, Royer-Greaves School for the Blind; J. D. Sneed, principal, Georgia Academy for the Blind; J. F. Curtis, psychologist, Illinois Braille and Sight Saving School; Robert McQuie, teacher, Missouri School for the Blind; Geraldine Chandler, teacher, Denver, Colorado; Sophia D. DeVryer, teacher, Zeist, Netherlands; Sister M. Helen Jean, teacher, Most Holy Redeemer Day School for the Blind; Miriam Norris, director, Greater Chicago Project on Blind Children; and Mrs. Lillian Nyvall, Elizabeth McCormick Memorial Fund, Chicago.

Research in Review

Conducted by Herbert Rusalem, Ed.D.

"Developing a Curriculum for the Blind Retarded," by Maurice A. Tretakoff and Malcolm J. Farrell. *American Journal of Mental Deficiency*, Vol. 62, No. 4, January 1958.

In an address before the annual meeting of the American Association of Instructors of the Blind in June 1956, Dr. Salvatore G. DiMichael, then executive director of the National Association for Retarded Children, estimated that there were four thousand blind-retarded children in the United States. This number constitutes some 10 to 14 per cent of the blind population in that age group. The apparent size of this group, as well as the mounting interest in the multiple-handicapped blind child, has encouraged the development of educational programs for them. In the main, these programs have emerged in the framework of day and residential schools. As a result, their emphasis has been upon the more intellectually able segment of the blind-retarded population. However, a significant proportion of these children are in the moderate and severe classifications (under 50 in intelligence quotient).

Blind children in this group tend to be placed in institutions. Originally, the institutional programs established for them were primarily custodial in character. The major effort was focused on providing a healthy and reasonably happy environment over the long term. Attempts at training and education were secondary in such programs. Within recent years, workers in the field of mental retardation have increasingly emphasized the potentialities of some children in the moderately and severely retarded groups to benefit from training. As a consequence, similar ideas began to permeate programs for the institutionalized blind and retarded individual. The Tretakoff-Farrell report discusses an effort in this direction.

THE STUDY. In February 1954, the Ransom A. Greene Blind Unit was established at the Walter E. Fernald State School in Waverly, Massachusetts, to accommodate blind-retarded children and adults. For the purposes of this report, the authors studied the characteristics of the first 160 admissions. All the members of the group were legally blind. About one third had retrolental fibroplasia, about one fourth had optic atrophy, and about one fifth had cataracts. The remainder were distributed among a large variety of eye conditions. More than 85 per cent of the group had brain damage associated with the visual and intellectual problems. Some 79 per cent of them had intelligence quotients under 50. Seventy-seven per cent of the group were under twenty-one years of age. There were 101 males and 59 females.

"Almost all of the admissions under ten years of age showed some sign of emotional disturbance. This was evident as displayed in tantrums, biting and kicking, pinching, and, in some cases, withdrawal. There is no doubt that this had an effect upon some of the psychological-test results." The highest academic achievement for a member of the group was third grade. Seventy-nine of them had had previous training, as follows: nursery training, 21; school for the blind, 28; public school or class at a state school, 30.

Based upon a study of the characteristics of the blind-retarded persons in this population, educational goals were estab-

lished. The rationale for these goals was: "From knowledge and experience with sighted retarded children, it is known that most of the mild group (I.Q. 50 and above) can become self-supporting citizens; the moderate group (I.Q. 20-49) can adjust to a sheltered-workshop status; and the severe group (I.Q. under 20) can lead satisfactory lives in a protective environment. Since the additional handicap of blindness enters into the habilitation problem of this group, there is no doubt that this has an adverse effect upon the above-stated objectives. It is known that about 70 per cent of all blind people in Massachusetts are presently unemployed in spite of a vigorous campaign by agencies for the blind. . . . Therefore, to be realistic, it is felt that the goals for the blind-retarded should be a sheltered workshop for the mild group and satisfactory adjustment to custodial life for the other groups. Of course, it is realized that there are always exceptions to any rule and additional experience may cause us to change our objectives."

The curriculum developed for this group, based upon a study of their needs, is an "open-end curriculum"—one which is changed and extended constantly. "Basically, however, the curriculum consists of play therapy, sense training, kindergarten, the primary grades, music, recreation, vocational training, and occupational therapy." The curriculum is implemented in a secure and stable environment. In setting up a program for an individual blind-retarded child, the following factors are considered: medical diagnosis, psychological-test results, social history, academic achievement, if any, and behavior observations made in the dormitory. There are no rigid requirements. The child is allowed to progress at his own rate of speed, with promotion occurring at any time during the year.

Some highlights of the program are:

1. Play therapy. The purpose of play therapy is to stabilize the child. It may require from three months to three years. Through holding the child, singing to him, and playing with him, the teacher develops a relationship with the child, stimulating the development of inner controls and an ability to accept environmental demands.

2. Sense training. The goal is to introduce the child to his environment and to promote feelings of security within it. The child is oriented to the physical setting. He is taught to discriminate sizes, shapes, weights, and textures. Travel techniques are introduced. Simultaneously, the development of expressive speech is encouraged. When the child gives evidence of talking and enjoying social relationships, he is thought to be ready for transition to a kindergarten class.

3. Kindergarten. Kindergarten stresses social training. As a member of a group of four children, the child is taught independence and group participation. Nature walks, parties, group singing, playing with blocks, stringing beads, lacing shoes, buttoning clothes, and discussing everyday matters are some of the activities planned. As the child advances, readiness programs in braille and sight-saving are introduced.

4. Academic subjects. Blind-retarded children in the mild group are taught academic subjects, but academic achievement is not emphasized. "We suggest the teaching of academic subjects since the children receive recognition for these achievements from their families and contemporaries. This is desirable for good mental health." Currently, no child goes beyond the fourth-grade level. Separate classes are held for braille and sight-saving pupils. No class exceeds eight in number. Among the subjects taught are reading, writing, arithmetic, spelling, and social studies.

5. Music. "Everyone who is able is exposed to music in its various forms. The small children learn nursery songs and participate in a rhythm band; the teen-agers concentrate primarily on popular music, although they show an interest in classical music." There are two choral groups, one for men, the other for women.

6. Wood-working shop. Teen-agers are

trained in the use of hand tools. When they acquire skill and can adapt to the environment, they may enter the woodworking shop, which serves as a sheltered institution. In this shop, the major activity is furniture repair. ". . . The shop is for adult men only and placement in it is a privilege; those who are selected gain prestige."

7. Recreation and physical education. "Swimming is, undoubtedly, our most popular form of recreation. Every child and adult who is physically able is scheduled for a swimming class in our indoor pool. Water seems to have a therapeutic effect upon the blind." Among the other activities scheduled are: adapted games, roller skating, adapted bowling, and dances. Ice skating and wrestling have not been successful with this group.

8. Occupational therapy. For those who are unable to perform the more complex operations of furniture repair, crafts are taught in a "semi-social atmosphere." Among the crafts used are: rug weaving, pot-holder weaving, basket weaving, and simple ceramics. The women do some knitting and crocheting. Occupational therapy also functions in relation to the "hard core group of very disturbed children." These cases are considered doubtful and require therapy over a long period of time.

The conclusions suggested by the authors are:

1. "Classification of blind-retarded according to present medical, psychological, and educational knowledge is feasible."

2. The majority admitted are in the moderate and severe groups. "However, a definite educational program can be developed for all groups."

3. "Since only 50 per cent of our age group of one to fifteen has retrolental fibroplasia, this program will continue indefinitely."

4. "While we feel that our curriculum has validity, we do not consider this to be the only approach to the problem."

5. "Many of the very young children are admitted with severe behavior problems (neuroses) which have to be treated before actual training can begin."

IMPLICATIONS. This study and the curriculum evolving from it are tantalizing. The force of logic is solidly supportive of the approach used. Yet, the reader is led from a definition of the need to an exposition of the program and is stopped at the threshold of real understanding. The true test of the Fernald State School program is still lacking. There is need for a well-planned research project evaluating the impact of the program upon groups and individuals. Until this is done, we have to reserve judgment on the efficacy of the program.

The most important implication for our field is that an apparently constructive program for the mentally retarded blind person is being carried forward in a state institution. In some communities, the members of this group are institutionalized for long periods of time, perhaps for life, and are permitted to stagnate and deteriorate. The meager existing evidence supports the belief that these individuals can benefit from training. They can be helped to become more self-sustaining, independent, and useful than was formerly supposed. In most cases, however, a constructive program for them is still lacking.

It seems that the attention of schools and agencies for the blind needs to be more actively directed toward the state institutions for the mentally retarded. As a first step, a statewide survey of the population within these institutions could be undertaken in an effort to identify those who are classified as blind. Secondly, a careful study can be made to ascertain the characteristics and needs of the blind-retarded residents. On the basis of these data, the staffs of the state schools can cooperate with representatives of schools and agencies for the blind to construct a training program. Such cooperative effort may encourage state institutions for the mentally retarded to provide improved educational service to blind-retarded individuals.

Directory Changes

The following changes within various agencies for the blind should be made in your *Directory of Agencies Serving Blind Persons in the United States and Canada,* 1959 edition:

Page 4—National Institute of Neurological Diseases and Blindness. Dr. Richard L. Masland replaces Pearce Bailey, M.D.

Page 14—American Foundation for Overseas Blind, Regional Offices. Far East: new address, Gochangco Building, San Luis Street. Latin America: new address, Agustinas 715, Of. 113-114.

Page 21—Alabama Institute for Deaf and Blind. New address: P. O. Box 17.

Page 33—Braille Institute Free Circulating Library. Henriette J. Sprangers replaces Mrs. Michael Briggs.

Page 34—Field Service for the Adult Blind. Bernece McCrary is now Supervising Teacher-Counselor.

Page 34—Braille Institute of America, Inc. A. T. Hunt's title becomes Executive Director.

Page 35—Sacramento Valley Center for the Blind. Mrs. Antoinette C. Septinelli, Acting (Executive Director), replaces Gladys C. Scott.

Page 41—State Welfare Department. Mary Turner replaces Udell La Victoire.

Page 41—State Board of Education of the Blind. H. Kenneth McCollam replaces Albert N. Sherberg.

Page 57—Books for the Blind, Library Association of Portland. Correct address: 216 N. E. Knott Street, Portland 12, Oregon.

Page 60—Illinois Industrial Home and Services for the Blind (2 listings). New name: Illinois Visually Handicapped Institute.

Page 69—Division of Services for the Blind, etc. Kansas Industries for the Blind. New address: State Office Building.

Page 96—Kansas City Nursery School for the Blind. Correct address: 1508 East 39th Street.

Page 102—Library Services. First sub-heading should read LENDING LIBRARY (Delete "and Distributor of Talking Book Machines"). Add second sub-heading and address: DISTRIBUTOR OF TALKING BOOK MACHINES: Bureau of Services to the Blind, Nevada State Welfare Department, 402 Clay Peters Building, 140 N. Virginia, Reno, Nevada.

Page 131—Library for the Blind. Correct address: 617 College Street, Cincinnati 2.

Page 137—Oklahoma League for the Blind. Correct address: 106 N. E. Second Street.

Page 140—Books for the Blind, Library Association of Portland. Correct address: 216 N. E. Knott Street, Portland 12.

Page 150—Pennsylvania Working Home for the Blind. Add: Neale Curtin, Acting (Executive Director).

Page 150—Philadelphia Association for the Blind, Inc. Delete J. F. Clunk.

Page 151—Catholic Guild for the Blind becomes The Greater Pittsburgh Guild for the Blind.

Page 169—Fort Worth Foundation for Visually Handicapped Children, Inc. Services temporarily suspended.

Page 169—Lighthouse for the Blind. Morris E. West replaces Mrs. M. J. Guthrie.

Page 170—San Antonio Association for the Blind. E. I. Mills, Jr., Manager, replaces A. M. Walker, Executive Director. New telephone number: LI 4-7636.

Page 170—San Antonio Council for Visually Impaired Children. Program suspended.

Page 172—Utah Schools for the Deaf and the Blind. Robert W. Tegeder replaces Harold W. Green.

Page 188—State Department of Public Welfare, Division of Public Assistance. New address: 1 West Wilson Street, Madison 2.

Page 200—Greater New York Council of Agencies for the Blind. New officers: President: Irving Miller, Vacation Camp for the Blind, 119 West 69th Street, New York 23, New York. Secretary-Treasurer (replaces office of Secretary): Ruth V. Friedman, American Foundation for the Blind, 15 West 16th Street, New York 11, New York.

Page 209—Lutheran Braille Evangelism Association. New address: 902 Hennepin Avenue, Minneapolis 3, Minnesota.

News Briefs

★ *The New Beacon* reports an agreement between the governments of the United Kingdom and the Union of Soviet Socialist Republics resulting in an exchange of delegations of three persons, during 1960, between the All-Russian Society of the Blind and the Royal National Institute for the Blind. The visiting groups will observe services for the blind for two weeks.

★ Mrs. Hazel C. McIntire retired last fall as director of special education in the Ohio Department of Education, after twenty-one years in that capacity, and more than thirty-six years of service in special education in her state. The division of special education under Mrs. McIntire's direction has concerned itself with gifted children of the state as well as with those who are physically or mentally handicapped. The directorship of the division, which now serves some sixty-five to seventy thousand children in Ohio, has been assumed by Raymond A. Horn.

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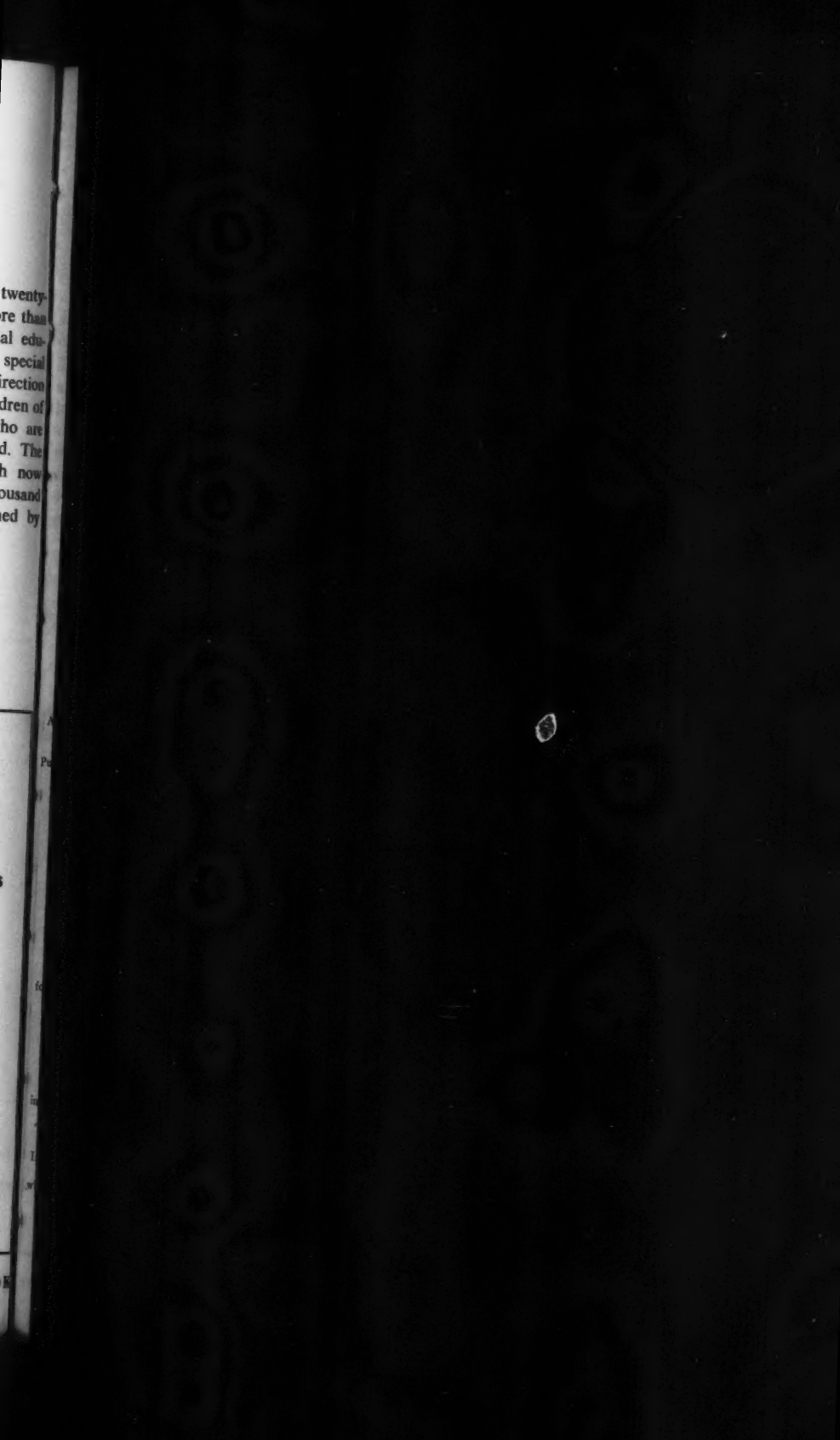
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